

KINSHIP CARE MONTHLY REPORT

Date: _____

To: Kinship Care Program Specialist
Child Welfare Services Section
Bureau of Programs and Policies

From: _____
County / Tribe

Re: Kinship Care Report for the Month of _____

Use of form: Submittal of the data on this report is required by DCFS Numbered Memo Series - 99-07. However, use of this form is voluntary. Counties / Tribes may elect to use their own reporting format.

Instructions: Submit the report by the 24th of each month. Record the month being reported, not the month in which it is sent. For example, the August report is submitted in September.

☐ Yes ☐ No We had a waiting list during this month.

If "Yes," the number of children currently on the waiting list is _____.

☐ Yes ☐ No Our County / Tribe funded Kinship Care placements with County / Tribal funds (i.e., funds other than our Kinship Care allocations) during this month.

If "Yes," the number of children supported by local funds this month is _____.

On the last day of the reporting month we had _____ children for whom we were making Kinship Care payments.

Of those payments, _____ were court ordered. (Include Long-Term Kinship Care children.)

☐ If there were no new cases, terminations, changes or denials, check this box to indicate we should not expect any forms to be attached to this cover sheet.

Mail to: Kinship Care Reporting
DHFS / DCFS / BPP
P.O. Box 8916
Madison WI 53708-8916

Fax to: (608) 264-6750

E-Mail to: murphr@dhfs.state.wi.us